E-ISSN 2281-4612
ISSN 2281-3993

Academic Journal of Interdisciplinary Studies

Vol 6 No 3
November 2017

DE GRUYTER OPEN

Research Article

Factors Relieving Perceived Living Difficulties in Patients with Depression

Mayo Hiroshima

Tokyo Healthcare University

Doi: 10.1515/ajis-2017-0025

Abstract

Based on interviews with 6 patients with depression, factors relieving perceived living difficulties among them were extracted using qualitative induction analysis. The following factors were extracted: self-cognition control, existence of family and being able to self-disclose to family, hours of the day, healthcare services, doing something, peer support (existence of peers, getting information), understanding at the workplace (understanding, carefree attitude), and casual address by nurses. These results suggested nursing care tips to relieve perceived living difficulties in patients with depression.

Keywords: *depression, perceived living difficulties, relieving factors*

1. Introduction

Depression is one of the most common psychiatric disorders; the lifetime prevalence rate is 6%. There are views that the prevalence rate of depression is still increasing with social changes in recent years. According to the Global Burden of Disease Study primarily conducted by the World Health Organization, major depression is listed as a contributing factor that would independently decrease Disability-Adjusted Life Years (Kanfer & Zeiss, 1983). Acceptance of mental disorders and mental health care in society as well as advances in antidepressant medications and cognitive therapy have produced significant outcomes in treatment of depression. However, in the treatment of depression, even when a patient achieves remission at the symptomatic level, recovery at the functional level cannot be as easily attained. Thus, difficulty in social reintegration could result from social dysfunction (Miyata et al, 2017). Moreover, patients with depression have low stress tolerance and low self-appraisal due to persistence of distinctive cognitive distortion and mood disorders (Tarumi, 2005). Thus, the perceived difficulties in daily life (perceived living difficulties) of patients with depression are greater than those seen as a phenomenon. Many patients with depression still have difficulties reintegrating into society such as returning to work even as they are in the recovery process while living their daily lives.

The traditional melancholic type of depression can often lead to depressed conditions caused by fatigue and exhaustion because of being scrupulous and considerate. People with this disorder generally present with feelings of self-responsibility or feelings of guilt along with depressive symptoms (Tarumi, 2005). In recent years, there has been an increase in the number of patients with “depression” presenting various clinical pictures. The dysthymic (Tarumi, 2005) and avoidant types of depression (Hirose, 2008) are widely known in society. These types of depression tend to be seen more often in younger age groups compared to melancholic depression, presenting with vague feelings of inadequacy and mental tiredness rather than feelings of guilt and sadness, with some cases being extra-punitive (Tarumi, 2005). People surrounding these patients may have “no first impression” rather than an impression of sadness about them (Tarumi, 2005), and their

difficulty in responding to the patients has been publicized.

Although, as described, various types of patient pictures of depression have been published, it is known that patients with depression, regardless of type, suffer mental distress because they stick to their ideas (Hiroshima & Kasai, 2013; Hiroshima, 2012).

Since subjectivity and perceived difficulties in patients with depression are regarded as important (Yip, 2004), there has been research on perceived difficulties in returning to work (Tanoue et al, 2012; Hinoguchi et al, 2016). However, no research has been conducted as yet focusing on perceived living difficulties in patients and identifying factors that relieve their perceived living difficulties. Perceived living difficulties are important issues directly linked to quality of life of patients. This study therefore aims to identify factors relieving perceived living difficulties in patients with depression.

2. Research Methodology

2.1 Participants

Of those diagnosed with mood disorders by experienced psychiatrists who had participated in a rehabilitation program at a research support facility, only those who consented to participate in this study were included. Participants were 6 patients with depression.

2.2 Data collection

Semi-structured interviews were conducted in accordance with an interview guide. A researcher with psychiatric nursing experience conducted interviews as an interviewer. The interviews were conducted using a room where there was no possibility for quiet voices to be overheard outside with time limited to up to 1 hour. When the researcher observed a participant's signs of fatigue, the researcher made sure of the participant's will to either continue or stop the interview.

Perceived living difficulties are difficulties that patients perceive while living their lives. They encompass hardship, predicaments, and difficulty that patients perceive without being conscious of them (or without being aware of them). To grasp the predicament that patients unintentionally feel in their daily lives without being conscious of it, I asked the patients to talk specifically about the following items: 1. the process until the patients were diagnosed with mood disorder; 2. impressive events and feelings at the event the patients experienced during the process until they were diagnosed with mood disorder, 3. how the patients are living their daily lives now, and 4. what the patients feel, think, and contemplate in their daily lives and things related to it.

2.3 Data Analyses

The contents of conversations were tape-recorded and transcribed verbatim. I read overall sentences thoroughly, and, from interview transcriptions, I extracted the experiences of patients with depression of resolving perceived difficulties in their lives and what they thought influenced it. Subsequently, I labelled the parts extracted from the interview transcriptions while adding a minimum number of words so that one unit had one meaning. I then sorted the labels based on similarities of semantic content.

This study was approved by the Ethical Committee of the researcher's institution prior to research work commencing.

3. Findings

The following factors were extracted as factors relieving perceived living difficulties in patients with depression: self-cognition control (e.g., I won't follow the directions they are pressing on me. I'm a person who doesn't think and want to go unconsciously. For this reason in particular, I've decided not to go that way), existence of family and being able to self-disclose to family (e.g., Family is the closest existence; that's the reason I wish I could communicate my feelings more assertively and

more frankly), hours of the day (e.g., I feel good in the evening), healthcare services (e.g., Return to work support, counseling, and consultation), doing something (e.g., Activities such as cleaning up or hobbies), peer support (existence of peers, getting information) (e.g., I was comforted when I talked with people with the same symptoms as me), understanding at the workplace (understanding, carefree attitude) (e.g., People around me don't care too much. They are more easygoing than I expected. Some people talk to me as usual and come into contact with me as usual), and casual address by nurses (e.g., When a nurse addressed me by asking "How are you doing?" I was comforted. When I was told "You are same as everyone else," I was convinced. I think everyone else is same as me in evening work, taking a walk, and casual conversations).

4. Discussion

Factors relieving perceived living difficulties in patients with depression included factors related to self-cognition, people around a patient such as family, people at the workplace, peer support, time, and healthcare services. Numerous studies have said that cognitive therapy (Lepping et al, 2017), rework programs (Yutani et al, 2016), a supportive surrounding environment, and feeling understood by people around a patient (Hatanaka, 2016) are important for the recovery from depression. Among healthcare services, nurses who are at a patient's bed side for 24 hours relieved perceived living difficulties in patients with depression through casual conversations and greetings. In outpatient nursing, patients cited no contact with nurses (no opportunity to talk to them) as a reason for not consulting them (Kita & Iwasa, 2017). Nurse-initiated casual conversation is therefore considered important. The findings suggested that, in nursing care for patients with depression, not only cognitive and drug therapy but also day-to-day casual address and interactions can help patients recover.

5. Conclusion

I interviewed 6 patients with depression and identified factors relieving perceived living difficulties in patients with depression using qualitative induction analysis. Consequently, factors relieving perceived living difficulties in patients with depression were found to be as follows: self-cognition control, existence of family and being able to self-disclose to family, hours of the day, healthcare service, doing something, peer support, understanding at the workplace, and casual address by nurses. These results suggest that casual day-to-day address and interactions by nurses may also be important in nursing care for relieving perceived living difficulties in patients with depression

References

Hatanaka, J. (2016). The structure of occupational health nurses' support for return-to-work to workers with depression. *Journal of Occupational Health, 58(4),* 109-117.

Hinoguchi, J., Nakamura, K., & Nakayama, K. (2016). A qualitative study on recovery experiences in patients with chronic depression who underwent inpatient Morita Therapy. *Report of Research Support of The Mental Health Okamoto Memorial Foundation, 27,* 91-94.

Hirose, T. (2008). Depression of avoidant type compared with depression of dysthymic type. *Japanese Journal of Clinical Psychiatry, 37 (9),* 1179-1182.

Hiroshima, M. (2012). Perception of living difficulties in patients with depressive disorders. *Journal of Neurochemistry, 123(suppl. 1),* 72–73.

Hiroshima, M., & Kasai, S. (2013). Perceptions of living difficulties held by patients with depressive disorders: Two case studies of patients with depression with and without typus melancholicus. *Health Sciences, 8,* 31-38.

Kanfer, R., & Zeiss, A. M. (1983). Depression, interpersonal standard setting, and judgments of self-efficacy. *Journal of Abnormal Psychology, 92,* 319–329.

Kita, E., & Iwasa, T. (2017). A study on depressive patients' thoughts during outpatient visits—The reasons for not consulting outpatient nurses when a patient is having suicidal ideation or being in a depressive state. *The Japanese Psychiatric Nursing Society, 59(2),* 274-278.

Lepping, P., Whittington, R., Sambhi, R. S., et al. (2017). Clinical relevance of findings in trials of CBT for depression. *Europian Psychiatry, 45,* 207-211.

Miyata, A., Iwamoto, K., & Ozaki, N. (2017). Thoughts about "True Recovery" in depression treatment: Desirable pharmacotherapy in considering depressive patients' reintegration into society. *Japanese Journal of Clinical Psychopharmacology, 20(3),* 277-282.

Yip, K. S. (2004). Understanding subjective depressive experiences of adolescents. *Hong Kong Journal of Paediatrics, 9,* 354–360.

Yutani, M., Magara, M., Jinnai, S., et al. (2016). Outcomes of the Keyaki-no-mori Hospital Rework Program. *The Journal of the Kanagawa Medical Association, 65,* 11-18.

Tanoue, A., Ito, D., Shimizu, K., et al. (2012). Depression, social function, and employees' difficulties in returning to work because of depression. *Japanese Journal of Behavior Therapy, 38(1),* 11–22.

Tarumi, S. (2005). Depression of dysthymic type fostered by modern society. *Japanese Journal of Clinical Psychiatry, 34,* 687–694.